Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Prescott's Orthotics & Prosthetics 6715 San Pedro San Antonio, TX 78216	MFDR Tracking #: M4-07-4957-01 DWC Claim #: Injured Employee: Date of Injury:
Respondent Name and Box #: State Office of Risk Management Rep. Box #: 45	Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary listed on the Table of Disputed Services: "W/C claim."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $330.20
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Pursuant to Rule 133.307(c)(1)(A) the requestor shall provide a copy for all medical bill(s) as originally submitted to the carrier for reconsideration in accordance with §133.250. In review of the dispute packet submitted by the requestor Prescott's Orthotics & Prosthetics for date of service 08/04/06, the Office found that the charges in dispute had not been resubmitted properly for reconsideration in accordance with Rule 133.250(d)."

Principle Documentation:

1. Response to DWC 60
2. Letter to Requestor dated 11/10/06

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	HCPCS Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
08/04/06	L1815-RT	57, W12	1, 2	$0.00
08/04/06	L2425-RT	57, W12	1, 2	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "57 – ICD-9 Code Unrelated to reported injury claim and "W12 – Extent of injury. Not finally adjudicated."
2. It appears that the Requestor submitted the first bill with a diagnosis code that was unrelated to the compensable injury. According to the CMS-1500, stamped with "Corrected Claim" the Requestor corrected and submitted the bill to the Respondent. Per 28 Texas Administrative Code Section 133.20(g) when a corrected claim is sent, it requires a request for reconsideration. Per 28 Texas Administrative Code Section 133.307(e)(2)(B) the Requestor has not properly requested reconsideration of the medical bill and therefore, this dispute is not ripe for Medical Fee Dispute Resolution. Reimbursement cannot be recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 133.304, 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	March 13, 2008 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.